Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert C. Jaehne, DC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-1787-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a denial for the remaining balance of this bill, stating 'WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERRORS WHICH IS NEEDED FOR ADJUDICATION; ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY; THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE; DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS.' However, this is incorrect.

99456 was the CPT code used to bill the Impairment Rating, with modifiers 'W5' and 'NM' because a doctor other than the treating doctor examined the injured employee; that doctor was acting as a TDI-DWC appointed designated doctor; the examination performed by the doctor was to determine MMI and/or IR; the injured employee is not at MMI. 99456-W6-RE was used because we're indicating that Dr. Jaehne was a designated doctor performing an examination that addressed the extent of compensable injury; 99456-MI was used to indicate that TDI-DWC requested multiple impairment ratings.

We billed a total of $950.00 for these services. *We have only received $900.00 from your company, which does not meet the Medical Fee Guidelines suggested payment amount of $950.00.* Please issue prompt payment in the amount of **$50.00** to settle this claim."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 4/22/14.

The requester billed Texas Mutual for 99456-W5/NM and paid the MAR for the code.

There three DWC69s in the DWC60 packet. All are checked the claimant is not at MMI, which corroborates code 99456-W5/NM. This is further substantiated by the requestor's narrative report.

The requestor billed 2 units of code 99456-MI. Rule 134.204(j)(4)(B) states, 'When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.' The requestor states in his narrative report the claimant 'Maximum Medical Improvement has not been reached.' The statement 'Maximum Medical Improvement has not been reached' is not a rating for which reimbursement can be issued. For this reason Texas Mutual declined payment of 1 unit. Texas Mutual inadvertently paid the other unit.

No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2014	Designated Doctor Examination	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 891 – No additional payment after reconsideration.
   - 892 – Denied in accordance with DWC rules and/or Medical Fee Guideline including current CPT code descriptions/instructions.
   - CAC-18 – Exact duplicate claim/service.
   - 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H).

Issues

1. Were the disputed services supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves charges for a designated doctor's findings of multiple impairment ratings. The requestor billed $100.00 for 2 units of multiple impairments. 28 Texas Administrative Code §134.204 (j)(4)(B) states, in relevant part, "When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and be reimbursed $50 **for each additional IR calculation**" [emphasis added]. Review of the submitted documentation finds that the designated doctor documented no impairment rating calculations, stating, "No impairment rating is determined at this time." Therefore, the disputed services are not supported.
2. The total allowable for the disputed amount is $0.00. The insurance carrier paid $50.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.